Idaho Medicare Rural Hospital Flexibility Program

EVALUATION SUMMARY REPORT

August 2005

INTRODUCTION

An evaluation of the Idaho Medicare Rural Hospital Flexibility (Flex) Program occurred from April 15 – August 15, 2005. Approximately 100 state and local stakeholders participated in the evaluation. This report documents the evaluation methods, findings, and outcomes and makes recommendations to further enhance Idaho's Flex Program.

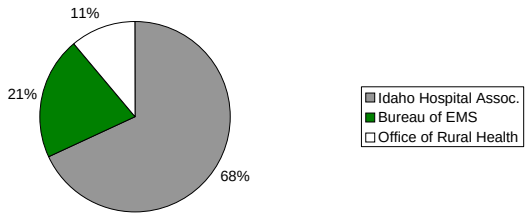
Rural Health Solutions, a rural health program development and research firm located in St. Paul, Minnesota conducted the Idaho Flex Program evaluation. Evaluation activities conducted include: focus groups, a survey, key informant interviews, documentation review, and a review of grants made. The evaluation incorporates information from prior evaluation activities in Idaho as well as the work of the national Flex Program Monitoring Team.

BACKGROUND

The Idaho Flex Program is managed by the Department of Health and Welfare (IDHW), Office of Rural Health and Primary Care. During the past six years, the Idaho Flex Program obtained $3,096,799, an average of $516,000 per year, from the Health Resources and Services Administration, Office of Rural Health Policy to implement the Flex Program in Idaho. This is 96% of its requested funding. As displayed in Chart 1: Flex Program Grant Administration, the majority of funding has been directed to the Idaho Hospital Association to assist hospitals with conversion to CAH status and to provide quality improvement (QI) and performance improvement (PI) support to CAHs. The State Bureau of EMS, another significant Flex Program partner, conducts EMS technical assessments and reassessments, provides training and workshops to local EMS, and administers grants. The Office of Rural Health and Primary Care supports CAH workshops and training, grants to CAHs and EMS, CAH QI, and contracts for program evaluation activities.

Idaho has 26 CAHs, 70% of the hospitals in the state. The Idaho Flex Program has focused on CAH designation and support, EMS planning, and quality and performance improvement, dedicating over 24% of funds on grants for community-based projects. Idaho Flex Program staff includes 0.30 FTE at the Idaho Department of Health and Welfare, Office of Rural Health and Primary Care; 1.0 FTE at the Idaho Hospital Association; and .35 FTE at the Bureau of EMS. Additional support is provided by Qualis Health, the states Quality Improvement Organization.

Chart 1: Flex Program Grant Administration



EVALUATION METHODS

The Flex Program evaluation was a five month project that included: a review of Flex Program documentation (e.g. applications for federal program funding); a review of grants made and follow-up reports (e.g. 112 grants); a Community Health Provider survey; state stakeholder, CAH administrator, and networks key informant interviews; a Director of Nursing (DON) focus group; and an EMS focus group.

A **Documentation Review** was conducted to gain a historical perspective of the program, to better understand stakeholders' roles and responsibilities, to determine the relationship between program activities and program outcomes, and to identify any trends or other program outcomes reported in past evaluations.

The **Community Health Provider Survey** was a mailed survey conducted in ten Idaho CAH communities. Data was collected to determine community provider knowledge of and involvement in the hospitals' conversion to CAH status, changes in practice patterns, and perceptions of the CAH. Fifty-two health care providers not affiliated with the local CAH (e.g. local public health, chiropractors, pharmacists) were surveyed. The survey response rate was 44%.

State Stakeholder, CAH Administrator and Network Interviews were used to measure strengths, weaknesses, and satisfaction with Flex Program operations, management, and implementation; to discuss their involvement in program development; to identify program outcomes; and to identify program planning, development, and implementation needs and next steps.

The **Director of Nursing and EMS Focus Groups** discussed CAH and EMS activities and outcomes that have resulted due to the Flex Program, identified CAH and EMS and community issues and concerns, and solicited recommendations for program next steps.

SUMMARY OF FINDINGS

The evaluation resulted in many findings. Key findings related to program implementations, CAHs, network development, and EMS are noted below.

Program Implementation

The Idaho Flex Program is working to address all required national program goals related to supporting and sustaining CAHs, QI, program evaluation, and goals related EMS. Stakeholders are satisfied with the implementation of the Idaho Flex Program and have used the technical assistance (TA), tools, workshops, and training made available. Key areas for improvement are program planning, communications, coordination, and grants administration.

- The Idaho Flex Program expedited the conversion of small rural hospitals to CAH status, having 62% of conversions completed during the first three program years. This allowed the program to invest resources in QI/PI early on.
- The majority of Flex Program funding overall has been directed to CAH related activities: hospital conversions to CAH status, QI/PI support, grants, training, and workshops.
- All CAHs in Idaho have received CAH conversion support, CAH TA and support, and grant funding as part of the Flex Program.
- CAH staff are aware of the TA available through the Idaho Hospital Association and they know which Idaho Hospital Association activities are funded through the Flex Program.
- CAHs trust the Idaho Hospital Association and believe that they have done a very good job in implementing Flex Program activities in Idaho.
- Some CAH staff are not aware of the roles and responsibilities of the Office of Rural Health and Primary Care and believe that communications could be improved.
- The Idaho Hospital Association submits quarterly and annual reports of it's Flex Program related activities to the Office of Rural Health and Primary Care; however, the reports include minimal to no information related to grants made, and the way they present information limits program-monitoring capabilities.
- There appears to be duplication in the work of hospital networks in the state and the Flex Program activities contracted to the Idaho Hospital Association.

> "It is the one place [IHA] where if you need services, it is a treasure-trove of assistance."
> *CAH Administrator*

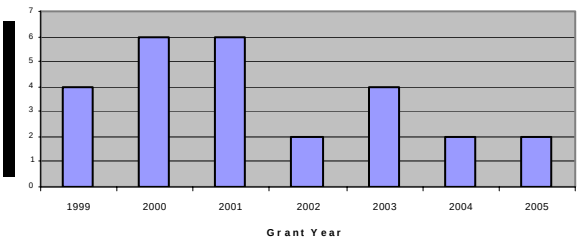
- Communication and coordination issues exist between the Office of Rural Health and Primary Care and the Idaho Hospital Association.
- Reports created using Idaho Flex Program funding are inconsistent in referencing the Idaho Flex Program and do not reference that the project was paid for by the Health Resources and Services Administration, Office of Rural Health Policy.
- Limited Office of Rural Health and Primary Care staff are available to plan, implement, and monitor Flex Program activities in Idaho. This does not appear to have had a negative effect on CAH conversions, TA, and support to CAHs, and may have expedited CAH conversions due existing relationships between the Idaho Hospital Association and rural hospitals. As the Flex Program moves beyond CAH conversions, the lack Office of Rural Health and Primary Care Flex Program staff may limit the program's development.
- CAH staff report that the QI Collaborative was good and they would participate in a future collaborative. CAHs report mixed perceptions of the Quality Indicators Project.
- 10 – 20 CAHs are represented at most Flex Program events organized by the Idaho Hospital Association.
- All but two CAHs have had staff participate in Flex Program funded activities in 2004-2005.
- 112 grants totaling $394,087 and an average of $15,157 per CAH have been made to CAHs in Idaho.

- Network coordinators report having little knowledge of and involvement in the Idaho Flex Program.

Critical Access Hospitals

- 27 hospitals have been certified as Critical Access Hospitals in Idaho. One CAH closed, leaving 26 active CAHs representing 70% of hospitals in Idaho.
- 58% of CAHs in Idaho meet the federally defined geographic qualifications for CAH status of being 35 miles from the next nearest hospital or more than 15 miles from the next nearest hospital but in mountainous terrain or in areas with only a secondary road.
- The majority of CAHs (62%) in Idaho converted to CAH status during the first three Flex Program years. This is a much higher percentage compared to other states' conversion activity over the same period (42%).

Chart 2: CAH Conversions By Grant Year



- CAHs averaged 0.63 deficiencies per survey in the initial Medicare certification survey, 3.36 deficiencies in the 1-Year reassessment survey and 4.69 deficiencies per survey in the 3-Year reassessment survey indicating an increasing number of survey deficiencies in CAHs.

> "We choose to immerse ourselves in the Flex Program. If you choose that, you are incredibly rewarded."
> *CAH Administrator*

- CAH Medicare Guidelines for Participation Tag numbers C0298, C0241, and C0337 consistently present issues during the CAH survey process.
- Nine CAHs have begun a Balanced Scorecard (BSC) process in their facility.
- CAHs have accessed an average of 15 Idaho Flex Program TA services per hospital over the past three years.
- CAH participation rates in Flex Program sponsored projects includes: 81% in the Credentialing Review Project, 88% in the quality review, 54% in Databank, 46% in the Peer Review Network, and 35% in the BSC.
- One CAH received no TA during the 2004-2005 grant year.
- Since conversion to CAH status, some CAHS have eliminated hospital services while the majority have added or upgraded services, in particular specialty outpatient services.

> "I think they [Flex Program staff] have had a difficult row to hoe and they have done a good job."
> *CAH Administrator*

- Some CAHs have issues with days in accounts receivable that have not been resolved.
- Networks report that at least one of their CAH network members is financially "fragile".
- CAHs overwhelmingly prefer smaller, less competitive grants to larger more competitive grants.
- 46% of community health providers working in CAH communities are aware that their hospital is a CAH and 7% were involved in the CAH decision-making process.
- Of the community health providers that knew their hospital converted to CAH status, 63% "strongly supported" or "supported" the decision while 33% were "undecided" and 4% were "opposed" to conversion.
- One CAH-based EMS said they were not involved in the CAH's decision to convert.
- 21% of community health providers describe their relationship with the CAH as "very strong", 39% as "strong", 18% "weak", 6% "very weak", and 15% "undecided".
- 23% of community health providers reported that their overall opinion of their local CAH and the care the provide is "very good", while 50% report "good", 6% "poor", and 21% "undecided".

Emergency Medical Services

- Outcomes related to the EMS technical assessments are mixed, while most believe the EMS reassessments have had no impact and should be discontinued.
- Of the nine CAH administrators interviewed that were aware of the EMSTAs, they predominantly

reported they were: not involved in the EMSTA, they were involved in the EMSTA but do not know what happened, or they delegated their involvement in the EMSTA and do not know what happened.

- A total of $339,000 in grants has been made to local EMS. This represents 11% of Flex Program grant funding.

> "They [EMS agency] felt that they became more organized because of it [EMS technical assessment] but I was not really involved because that was peripheral to us."
> *CAH Administrator*

- Although the majority of grants made to EMS were intended to address issues identified in the EMS technical assessments, most of the grant funding was directed to purchase equipment. In addition, there was no grant outcomes data that could be directly attributed to the grants made.
- All state Flex Program stakeholders familiar with the EMS training developed and administered by the Bureau of EMS report that it has had a positive impact on rural EMS.

> "It [EMS technical assessment] is an excellent tool to evaluate what we've been doing right and what we need to work on."
> *EMS Stakeholder*

ISSUES AND NEEDS

Rural community health, CAH, and other issues and needs were identified as part of the Flex Program evaluation process. Below is a list of the most common issues and needs identified, the most common being the growing number of people that are uninsured and uninsured.

- Uninsured and underinsured
- Access to mental health and oral health services
- Information technology (e.g. electronic medical records)
- Capital financing and capital financing information
- Health disparities
- Increasing rates of chronic disease yet fewer resources to address the issues
- EMS business planning models
- EMS recruitment and retention
- Collaboration amongst local health care providers
- EMS decision makers lack of expertise related to EMS
- Quality improvement

RECOMMENDATIONS

The following recommendations are based on the data, documentation, interviews, observations, and analysis that were part of the evaluation. Recommendations are intended to assist Idaho in developing an already successful Flex Program and are directed to all Flex Program stakeholders, in particular the Idaho Hospital Association, Bureau of EMS, Office of Rural Health and Primary Care, Qualis Health, CAHs, and networks in Idaho. Recommendations are <u>not</u> reported in order of priority.

1) Idaho should re-engage in a formal Flex Program strategic planning process.
2) Idaho should establish a Flex Program communications plan that reports on activities, changes, and updates.
3) Idaho should actively engage its hospital networks in the Flex Program.
4) Changes should be made in the administration and monitoring of the Idaho Flex Program.
5) Idaho should address issues related to grants administration.
6) Idaho should discontinue the EMS reassessments unless requested by EMS communities and EMS program planning should be re-visited as part of the Flex Program strategic planning process.
7) Idaho should consider responding to CAH technical assistance needs identified as part of the evaluation (e.g. electronic medical records, financial issues, frequently identified survey deficiencies).
8) Idaho should continue to monitor and evaluate program outcomes.

Idaho State Office of Rural Health & Primary Care

This evaluation was conducted by Rural Health Solutions, St. Paul, Minnesota - www.rhsnow.com, funded by the Idaho Department of Health, Office of Rural Health and Primary Care, through a grant from the U.S. Department of Health and Human Services, Health Resources and Services Administration, Office of Rural Health Policy.